Editorial

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Barriers to a career in intensive care medicine

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Background

Intensive care medicine (ICM) is an under-resourced area of the medical workforce that has traditionally been viewed as a difficult, demanding career of limited time frame but current legislation requires career intensivists to undergo specialist training.[1] The most recent position paper of the FICM Workforce Advisory Group found that the demand for ICM services, from 2013–2035, is projected to increase from anywhere between 25% and 125%.[2] This will require a proportionate increase in the number of both training and consultant posts.

The worrying future of ICM?

With the introduction of the controversial new junior doctor contract, trainee morale being at an all-time low and continued dissatisfaction with training and rotas,[3] the number of doctors required to meet projected work-force requirements for ICM and other acute medical specialties may be inadequate. A recent survey of emergency medicine trainees found that around one in four trainees planned to either leave the specialty or the UK for Australia or New Zealand.[4] However, between 2012 and 2016, 498 doctors have joined the new ICM curriculum. Despite an increase in the number of training posts available each year, more than 90% of training posts were filled in the most recent recruitment round.

Possible reasons for not choosing a career in ICM include working long anti-social hours, burnout, high-pressure decision making and long-term sustainability. Other reasons include an increase in portfolio medical careers and a societal trend towards better work-life balance. Women now constitute 55% of all training grades, although only a minority of ICM consultants are women. This disproportionate number of women in training and ICM consultant posts is a concern for ICM recruitment and retention. Data from the BMA 2014 Medical Workforce Briefing[5] show that females are more likely to have a lower work-force participation rate (full-time equivalent number of doctors divided by the head-count number of doctors) suggesting that female doctors tend to work less than full time. Although the number of women in ICM is increasing, only 17% of ICM consultants in the UK are female which is similar to other western countries.[1,5]

What are possible barriers to choosing a career in ICM?

The Intensive Care Society's trainee committee developed a survey to assess current opinions and concerns around a career in ICM. The aim was to evaluate what could be addressed during training and in work-force planning to achieve a sustainable career path; 656 responses were received, 406 (62.5%) of respondents were male, 413 (69%) responses were from ICM doctors (consultants and trainees) and the remainder non-ICM trainees (i.e. single specialty anaesthetic, medical, surgical, emergency medicine). Unit consultant workforce gender mix was predominantly male in 507 (78.2%) of responses with the rest being female (1.2%) and evenly mixed (20.5%).

The number (%) of responses for reasons for choosing a career in ICM were acute nature of clinical cases – 489 (91.4%); practical skills – 424 (79.3%); variety of patients – 395 (73.8%); generalist nature of work – 330 (61.7%); multidisciplinary working – 263 (49.2%); excellent nursing staff – 226 (42.2%); and research possibilities – 106 (19.8%); 520 (90.4%) of respondents had good role models in their units with 72.9% stated having an equal number of both male and female role models.

When asked about concerns for choosing a career in ICM, the reasons were *work-life balance* – 417 (76.7%); *sustainability/burn-out* – 422 (76.7%); *anti-social shifts* – 261 (48%); stressful environment to work in – 212 (39%); psychologically demanding/upsetting area to work in – 189 (34.7%); further

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examinations – 164 (30.1%); lack of private practice – 97 (17.8%); and male dominated – 57 (10.5%).

Four hundred and seventy-six (82.6%) respondents stated that they had never been asked about plans for a family or less than-full-time (LTFT) working. Only 24 respondents worked LTFT with 17 (81%) being for childcare reasons. Nine respondents (36%) had rota issues and six (31.6%) did not feel they gained the same training experience when working LTFT. Sixteen of these respondents 'agreed' or 'strongly agreed' that ICM was a good career for those working less than full time with the rest stating 'neutral' or 'disagree'.

How significant is the issue of gender-imbalance?

Although our survey was not specifically set out to address the challenges faced by female trainees, a recent survey of female fellows of the College of Intensive Care Medicine of Australia and New Zealand aimed to identify the challenges faced by female ICM trainees.[6] The response rate was high – 80.3% (127/158). The author found that 81% were satisfied with their experiences but 37% felt disadvantaged because of their sex. Other major gender-related issues raised included balance between work, life and raising children, sexism in the workplace and difficulties with academic advancement. More than half were mothers; 70% had returned to full-time work with childcare most commonly being undertaken by a family member or nanny. The majority of women took six months of maternity leave with several respondents stating they experienced resentment from colleagues when they were on leave and absent from the roster. Only 50% of respondents stated that their work-life balance was satisfactory but when all the respondents were asked 'Knowing what you know now, would you still chose a career in intensive care medicine?', over 80% of respondents answered 'Yes'. Whether the same holds true for female ICM trainees in the UK requires investigation.

The issue of gender imbalance becomes more prominent in positions of leadership in ICM, on the boards of major intensive care societies, and in academic ICM. Women only make up 10% of clinical directors of ICUs in Australia and New Zealand. Female representation is less than 25% on the boards of the Australia and New Zealand Intensive Care Society. European Resuscitation Council, European Society of Intensive Care Medicine, Faculty of Intensive Care Medicine and Intensive Care Society.[7] Women only comprised 17.5% of the editorial boards of the five highest ranked ICM journals which was the lowest of all examined specialties, including orthopaedic surgery.[8]

What are the possible solutions?

The ICM community now needs to address how the onerous out-of-hours commitments can be tempered as the clinician ages through improved rosters, how to promote ICM as an attractive career option, early identification of stress and burn-out and how early psychological support can be easily provided to alleviate this. An example of attempting to address the latter is the US Critical Care Societies Collaborative *Call to Action on Burnout Syndrome*. The issue of gender balance can be tackled through implementing cultural changes, overcoming gender bias on leadership and academic appointment (for example, by blinding gender to selection panels), developing structural changes that allow shared maternity leave schemes for men, more part-time appointments (without compromising continuity of patient care), use of positive role-models and promoting advocacy schemes such as Women in Intensive Care Medicine Network.[9]

Conclusions

ICM is a fundamentally tough career choice, and the nature of the job is likely to get more challenging in the current economic and political climate. This survey has highlighted several concerning areas that need addressing to ensure the sustainability of the specialty.

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